



Geriatric Care: Are We Patient Friendly?

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ABSTRACT

Objectives: To study family satisfaction of medical care to geriatric patients and to find out any difference in family satisfaction given by geriatric specialist and general medicine specialist. Indian data on family's perception of geriatric care is lacking.

Materials and methods: All geriatric patients who were admitted between March 2015 and September 2015 in medical wards and where hospital stay was more than 3 days were included. An internationally validated family satisfaction questionnaire was used and administered to family member of each patient admitted. Scores were graded on Likert scale under five important areas like staff interaction, support services, quality of medical care, medical communication, and facilities. Special comments were analyzed separately.

Results: Patients' family members were most satisfied with quality of medical care and facilities (95%), followed by staff interaction and support facilities. Satisfaction regarding medical communication and services was poor (60%). There was no significant difference for satisfaction/perception of quality of care given by geriatric specialist and general medicine specialist.

Conclusion: Medical communication and support services of long-term care of geriatric patients are an important area of improvement. Family perception of geriatric care is vital to overall delivery of health care to this vulnerable group of patients. Support facilities specifically designed for geriatric patients need to be strengthened. There was no significant difference in perception of care offered by geriatric specialist and general medicine specialist.

Keywords: Family satisfaction, Geriatric care, Geriatric care specialist medicine.

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INTRODUCTION

Elderly or old age consists of aged nearing or surpassing the average life span of human beings. The boundary of old age cannot be defined exactly because it does not have the same meaning in all societies. Government of India adopted "National Policy on Older Persons" in January 1999. The policy defines "senior citizen" or "elderly" as

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a person who is of age 60 years or above. The elderly population which accounted for 6.7% of total population in 1991 is expected to increase its share to more than 10% by the year 2021. Among the states, the proportion of elderly in total population varies from around 4% in small states like Dadra and Nagar Haveli, Nagaland, Arunachal Pradesh, Meghalaya to more than 8% in Maharashtra, Tamil Nadu, Punjab, Himachal Pradesh, and 10.5% in Kerala in the recent census.¹

The prevalence of disease in elderly is significant each year; around 5 million elderly patients are admitted to hospitals in India. Family members of elderly patients face unfamiliar stressful environment while they care for their elderly family member. High-quality medical care should be both patient and family centered. In our society, family support carries abundant significance. However, in reality, families' expectations and needs from health-care providers become secondary to the patients' medical care.²

Understanding and meeting the needs of the family members of the elderly patients is important. In the geriatric wards where the majority of patients are unable to participate in decision making about treatments, due to existing comorbidities (Fig. 1), the family's perspectives become central to understanding and measuring the satisfaction with the medical care provided.³

In the subset of elderly patients, studies on patients' family satisfaction are few in number and limited in scope. Culturally and socially, Indian families differ significantly as compared with those in the west; their expectations, needs, and factors contributing to their stress are likely to be different than those of the western

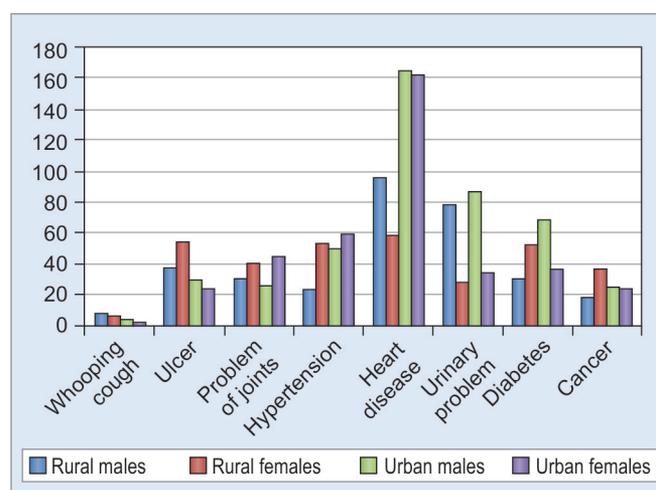


Fig. 1: Persons aged 60 years and above reporting a chronic disease (per 1,000 persons)

families. Therefore, this study was conducted to assess family satisfaction of medical care given to geriatric patients and to assess whether it differed in families of patients admitted directly under geriatric specialist from those admitted under general medicine specialist.

AIMS AND OBJECTIVES

Aim

To study the family satisfaction of medical care given to geriatric patients at a tertiary care teaching hospital in Navi Mumbai.

Objectives

- To evaluate and determine the family satisfaction of medical care given to geriatric patient by using CARENET family satisfaction scale which was modified in order to meet the requirement of our study.⁴ Permission for Scientific Committee was sought.
- To compare family satisfaction of medical care between geriatric consultant- and medical consultant-treated patients.

MATERIALS AND METHODS

Design of the study: This is a prospective, cross-sectional, observational, questionnaire-based survey. Family members of 200 consecutive geriatric patients fulfilling the inclusion criteria were enrolled.

Duration of the study: March 2015 to September 2015.

Setting: The study was conducted in a tertiary care teaching hospital in Navi Mumbai. The medical ward is a 180-bed, multidisciplinary ward, which admitted both medical and surgical patients. Physicians, who were not necessarily geriatric specialists, were also primarily responsible for the care of the elderly. The health-care team included the primary team admitting the patient from emergency department, a medicine department, and separate geriatric department along with bedside nurses and technicians with the average nurse-to-patient ratio 1:5. There is also separate rehabilitation department along with two patient/family counselor and a full-time dietician. Elderly patients are usually admitted in either medicine department or directly to geriatric department. Families were counseled by admitting physician. Families were allowed to be at the bedside when end-of-life care was being provided for terminally ill patients.

Inclusion: Patients of age more than 60 years who stayed in medical wards for more than 3 days were included in the study. The minimum stay of 3 days in the wards was chosen to ensure that the family member had adequate time and exposure to hospital environment. Only one family member in each patient's family – the

key decision maker – was identified as spokesperson and was surveyed.

Exclusion: Patients less than 60 years were not included. Elderly patients admitted in the intensive care unit and those not willing for informed consent and participation were not included.

Sample size: We decided to include 200 consecutive patients arbitrarily, as we did not have any previous studies showing us a response rate or prevalence of specific variables.

Data collection: The questionnaire was administered on day 4 of the patient's hospital stay. Family members of geriatric patients were recruited consecutively, using the inclusion criteria. The questionnaire was administered in the privacy of special room in wards. All participants were specifically assured that their results would be kept confidential. For patients who stayed more than 3 weeks, the same questionnaire was administered on the 22nd day. *Survey questionnaire:* An internationally reliable and validated family satisfaction scale⁴ was adapted and modified to suit our setting. The questionnaire was administered. The questionnaire included the demographic details of patients such as age, gender, and date of admission, family members' relationship to patient (optional), physician under which the patient was admitted, and satisfaction scale items, which included self-rated levels of satisfaction with five identified key aspects of care related to the overall hospital experience like how the patient and the family member were treated, communication by the ward team, and support facilities. The survey consisted of 15 questions in five categories, patient quality care, medical communication, staff interaction, support services, and facilities. The answers were set to a Likert scale of 1–4, scoring was based on the scale, 1 denoting excellent/completely satisfied and 4 very poor/very dissatisfied. The space was provided for suggestions and comments (optional).

As the study was part of an ongoing quality improvement effort, ethical committee approval was not sought. The respondents were informed that participation was voluntary, and consent was implied by the completion of the survey.

Data analysis: Collected data for all the parameters were coded and analyzed with the statistical software Statistical Package for the Social Sciences (SPSS) 17.0 (SPSS IBM, USA). Descriptive statistics were calculated to describe the distributions of individual items and the summary scores. Means, medians, standard deviations, frequency tables, rates, and proportions were computed to describe the answers for each question and each category. Percentage of positive responses for each item was also computed. Answers that scored 3 and 4 were considered as a negative perception or not satisfactory. The scores were also standardized using the standardization formula

(Standardized Score = [Observed Score – Minimum Score]/[Maximum Score – Minimum Score]). The resultant scores in the scale of 0–100 were cut into halves using 50 as the midpoint. Chi-square tests were used to compare the satisfaction levels between families of patients admitted under geriatric specialist and general medicine specialist. t-tests were performed to compare the mean satisfaction before and after a long stay.

For all the statistical tests, $p < 0.05$ was considered as statistically significant.

RESULTS

A total of 200 family members of geriatric patients who stayed in the wards >3 days were interviewed. One family member each for 200 patients completed the survey with 100% response rate. Of the 200 geriatric patients, 131 (65.5%) were males; 47 (23.5%) patients were admitted under geriatric specialist and 153 (76.5%) were admitted under general medicine specialist. Answers to individual questions were assessed, and proportions calculated, with higher scores indicating greater satisfaction (Fig. 2). The majority of respondents (189/200) were satisfied with overall care (95%).

The overall satisfaction response is summarized in Fig. 2. Families reported the greatest satisfaction with patient care (94.5%) and staff interaction (90.5%). They were less satisfied with the medical communication and support services (60.5%). Chi-square tests were performed for each of the five satisfaction domains to find out the association of satisfaction between geriatric specialist and general medicine specialist-treated patients. The results revealed no statistically significant differences between both the groups (Table 1).

Satisfaction scores of patients admitted in the Department of Geriatrics and Medicine are shown in Tables 1 and 2 and Figures 2 and 3. Median scores were compared

Table 1: Comparative data showing the satisfaction of patients admitted in Departments of Geriatrics and Medicine

Family satisfaction domains		Geriatric	Medicine	p-value*
Patient care	Satisfied	43	146	0.301
	Unsatisfied	4	7	
Staff interaction	Satisfied	45	140	0.334
	Unsatisfied	2	13	
Medical communication	Satisfied	43	144	0.523
	Unsatisfied	4	9	
Facilities	Satisfied	35	98	0.186
	Unsatisfied	12	55	
Support services	Satisfied	38	121	0.793
	Unsatisfied	9	32	

*p value obtained by using chi-square test

Table 2: Comparison of median scores: geriatrics and medicine

Category	Median score	
	Geriatric consultant	Medicine consultant
Patient care	4.0	4.0
Staff interaction	4.0	4.0
Medical communication	3.5	4.0
Facilities	3.5	4.0
Support services	3.0	3.0

between geriatric and medical consultant. There were 7 patients who stayed in the wards for more than 3 weeks during the study period. There was no statistical significance between their “before and after” satisfaction scores.

Quantitative and Qualitative Data/ Written Comments

We analyzed the written comments, as they may add important insights not captured by the scores. More than half of the respondents in our survey provided comments; there were totally 103 comments (51.5%). Most comments related to communication with attendants

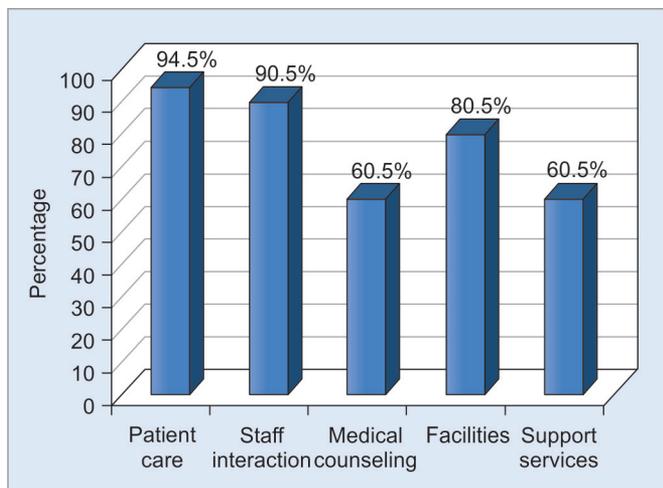


Fig. 2: The satisfactory response

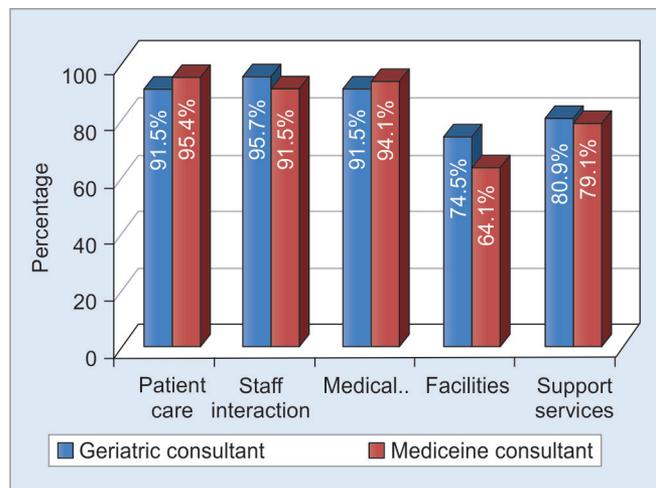


Fig. 3: The comparative satisfaction of patients admitted in Department of Geriatrics and Medicine

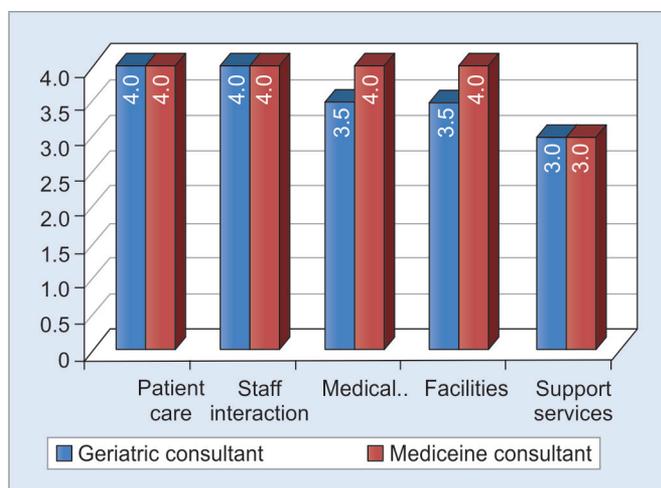


Fig. 4: Comparison of median scores between geriatrics and medicine consultant

followed by facilities provided for the families (rehabilitation measures, ambulation, speech, hearing, vision transportation for elderly in hospital). A total of 21 of the 103 comments (20.3%) were appreciations of overall care provided (Table 3). The number of positive and negative comments seemed to be in concordance with category-specific and overall satisfaction scores (Table 4). Most of the comments/suggestions were regarding communication being inadequate and ineffective.

DISCUSSION

Patient satisfaction is very much dependent on the interaction style and age of the patient. Mitchell Peck⁵ found that understanding the factors and processes that determine patient satisfaction can ultimately significantly improve the many facets of health-care delivery. Sørensen et al⁶ also consider the impact of individual differences when preparing the future care of adults. As matters stand presently, there is unfortunately a paucity of evidence on the effectiveness of end-of-life programs. Its effects on patients dying in an acute geriatric hospital setting are unknown.⁷ Limited research funding leads to sparse and often contradictory palliative care and patient satisfaction literature, with few studies on causal mechanisms.⁸ The key findings of our study suggest that overall the percentage of satisfaction was higher. Families reported greatest satisfaction with patient care (94.5%), staff interaction (90.5%), while being less satisfied with the medical communication and support services. This less satisfied domain needs to be further addressed. There have been a few studies that have attempted to research the expectations of geriatric patients in the developing world. Taimur Saleem et al's research in Pakistan attempted to find out the main causes of geriatric ill health and what produce high levels of patient satisfaction. Diabetes mellitus, hypertension, arthritis,

and renal disease were common ailments among geriatric patients. However, it was clear that the patient satisfaction was mostly dependent on the way the prognosis is delivered by the physician: a realistic but optimistic picture was a certain way of achieving a high degree of patient satisfaction. Other factors that ensured a high degree of satisfaction was the opportunity to discuss treatment options, prescribing fewer rather than more medicine as well as the physician's overall knowledge of expertise in geriatric health.⁹

Also research in elderly care done by Sihame Lkhoyaali et al in Morocco focused on the role relatives play in caring for elderly cancer patients; 86% of relatives participated actively in the treatment making decisions of their elderly loved ones. However, the emotional cost of such care was high: 79.3% of relatives suffered from anxiety and 10% used anxiolytics; 38% also felt guilty for neglecting the early symptoms of their relatives. Depression and anxiety were more frequent among female relatives and among those of urban origin.¹⁰ Another study in Sri Lanka looked at the challenges posed by the changing socioeconomic landscape and its impact on care for the elderly. Although both elders and caregivers still felt that elders should be looked after in the children's home, it was nonetheless clear that such an arrangement faced several challenges both from elders' viewpoint and the caregivers themselves. Elders feared losing their independence, while households where both the adult child and his/her spouse worked outside the home; households where elders had a disproportionate amount of household work; economically stressed households; and lack of direct communication between elders and caregivers also contribute to conflicts.¹¹ Another area that has been extensively researched is how the physician's personality can positively impact on patient care. Loyalty and trust in the physician's ability minimized patients.^{12,13} A good physician-patient relationship increases patients' trust and willingness to communicate, so an awareness of the factors that influence this relationship is essential. Liang CY et al,¹⁴ found that general practitioners could contribute massively to patients' well-being by helping older patients access health care and by extension improving the physician-patient relationship. Additional studies also found out that communication may best be achieved through efforts directed at those in earlier stages of the doctor-patient relationship.¹⁵ Communication in the care of patients, with advanced and serious illness, can be improved using quality improvement interventions, particularly for health care utilization as an outcome. Interventions may be more effective using a consultative approach.¹⁶ It has also been found that patient-centered communication is critical to quality cancer care in the

elderly as it helps patients and family members cope with cancer, make informed decisions, and effectively manage their care.¹⁷

However, balancing patients’ best interests and the health-care scarce resources is a hard act at the best of times. Physicians often make nuanced trade-offs in clinical practice aimed at efficient resource use within a complex flow of clinical work and patient expectations. Understanding the challenges faced by physicians and the strategies they use to exercise cost-consciousness provides insight into policy measures that will address physician’s roles in health care resource use.¹⁸ Interestingly, the literature also suggests that patient-centered behavior was more dependent on the personal characteristics of the physician than the age, gender, dementia severity of the patients.¹⁹ Another barrier identified to effective care was the lack of collaboration between health care professionals. Interprofessional work to deal with uncertainty and maintain coordinated care is needed for better palliative care provision to noncancer patients in the community. More research into development of a best model for effective interdisciplinary work is needed.²⁰ Ironically, more people die in hospital than in any other setting and it has been noted that care inputs operate in a mutually reinforcing manner to generate care outcomes, which implies that improvements in one area are likely to have spill-over effects in others.²¹ Teamwork should be reinforced and actively encouraged.

CONCLUSION

Family members of elderly patients overall seem to be satisfied with our current services. There were no differences in family satisfaction whether the patients were admitted under geriatric specialist and medicine consultant. Family members expect better communication skills and rapport with the patients and relatives and involvement of family members in decision making. They also expect better support services for elderly patients and rehabilitation measures. Domains of low satisfaction provide a target to improve the quality of care both for the patients and their families.

IMPLICATIONS FOR PRACTICE

Training can be implemented to inform a team about the communication challenges, to equip them with effective communication skills, and improve their receptivity to patient cues. Information sharing can be used as a nonthreatening approach to initiate rapport-building and open communication. Team should consider patients’ psychological readiness to communicate and respect their preference as to whom they wish to share their thoughts/emotions with. Hospitals/institutions also need to ensure

Table 3: Positive and negative comments

Issues	Number of suggestions	Number of comments	
		Positive	Negative
Support services	23/103	34	66
Communication to attendants	11/103	88	12
Facilities	10/103	80	20

Table 4: Details of written comments

Categories	Number of comments
Support services	23
Appreciation	21
Communication to attendants	11
Facilities	10
Patient care	9
Satisfactory	7
Attendant care	7
Cost	6
Others	9
Total	103

a supportive ward culture and appropriate workload that will enable nurses to provide holistic care to patients.

IMPLICATIONS FOR RESEARCH

Further research on the effect of the Asian culture on effective communication within the ward setting is required to expand the knowledge in this area. Studies to ascertain the effect of the patients’ age and place within the treatment cycle are also warranted. The lack of evidence on the effectiveness of postbasic communication education also requires further investigation.

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